

Facility Name & ID Number AVENUE CARE NURSING & REHAB CENTER

0050732 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,575	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 3 4 5 Patient Days by Level of Care and Primary Source of Payment				
		Medicaid Recipient	Private Pay	Other	Total	
8	SNF			3,173	3,173	8
9	SNF/PED					9
10	ICF	44,663	665		45,328	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,663	665	3,173	48,501	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 85.73%

D. How many bed-hold days during this year were paid by the Department?

656 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.

(E.g., day care, "meals on wheels", outpatient therapy)

NONE

F. Does the facility maintain a daily midnight census?

YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES NO

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES NO

I. On what date did you start providing long term care at this location?

Date started 02/01/88

J. Was the facility purchased or leased after January 1, 1978?

YES Date 02/01/88 NO

K. Was the facility certified for Medicare during the reporting year?

YES NO If YES, enter number of beds certified 21 and days of care provided 3,173

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRAUAL MODIFIED CASH* CASH*

Is your fiscal year identical to your tax year? YES NO

Tax Year: 12/31/2009 Fiscal Year: 12/31/09

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number

AVENUE CARE NURSING & REHAB CEN

0050732

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	191,581	24,004	9,796	225,381		225,381	225,381			1
2	Food Purchase		217,331		217,331	(22,010)	195,321	(311)	195,010		2
3	Housekeeping	145,485	31,004		176,489		176,489		176,489		3
4	Laundry	67,204	15,339		82,543		82,543		82,543		4
5	Heat and Other Utilities			154,413	154,413		154,413		154,413		5
6	Maintenance	75,499	29,965	42,558	148,022		148,022	16,178	164,200		6
7	Other (specify):*			31,453	31,453		31,453	101	31,554		7
8	TOTAL General Services	479,769	317,643	238,220	1,035,632	(22,010)	1,013,622	15,968	1,029,590		8
	B. Health Care and Programs										
9	Medical Director			6,000	6,000		6,000		6,000		9
10	Nursing and Medical Records	1,784,700	86,298	1,745	1,872,743		1,872,743	26,437	1,899,180		10
10a	Therapy	81,767	8,396	16,721	106,884		106,884	6,650	113,534		10a
11	Activities	79,658	16,505	2,496	98,659		98,659		98,659		11
12	Social Services	64,045			64,045		64,045		64,045		12
13	CNA Training										13
14	Program Transportation			76	76		76		76		14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	2,010,170	111,199	27,038	2,148,407		2,148,407	33,087	2,181,494		16
	C. General Administration										
17	Administrative	152,803		125,000	277,803		277,803	(10,450)	267,353		17
18	Directors Fees										18
19	Professional Services			111,743	111,743		111,743	(68,716)	43,027		19
20	Dues, Fees, Subscriptions & Promotions			40,805	40,805		40,805	(35,488)	5,317		20
21	Clerical & General Office Expenses	51,907	19,666	152,616	224,189		224,189	(29,987)	194,202		21
22	Employee Benefits & Payroll Taxes			447,527	447,527	22,010	469,537		469,537		22
23	Inservice Training & Education							1,123	1,123		23
24	Travel and Seminar			2,952	2,952		2,952	226	3,178		24
25	Other Admin. Staff Transportation			830	830		830	11,562	12,392		25
26	Insurance-Prop.Liab.Malpractice			309,952	309,952		309,952	1,694	311,646		26
27	Other (specify):*			22,000	22,000		22,000	28,630	50,630		27
28	TOTAL General Administration	204,710	19,666	1,213,425	1,437,801	22,010	1,459,811	(101,406)	1,358,405		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,694,649	448,508	1,478,683	4,621,840		4,621,840	(52,351)	4,569,489		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
1	DIETARY	
	DIETITIAN CONSULTANT XVIII B 35-2	8,570
	REPAIRS & MAINTENANCE	1,226
		0
		9,796
3	HOUSEKEEPING	
		0
		0
		0
4	LAUNDRY	
	EQUIPMENT REPAIRS & MAINTENANCE	0
		0
		0
5	HEAT & OTHER UTILITIES	
	GAS HEAT	65,494
	ELECTRICITY	51,308
	WATER	33,501
	CABLE TV - LOBBY	4,110
		0
		154,413
6	MAINTENANCE	
	GROUNDS MAINTENANCE	2,530
	PAINTING & DECORATING	1,140
	BUILDING REPAIRS	0
	MAINTENANCE TRAVEL	0
	EQUIPMENT MAINTENANCE & REPAIR	12,187
	ELEVATOR MAINTENANCE & REPAIR	11,311
	OUTSIDE LABOR	0
	EXTERMINATING SERVICE	6,170
	FIRE SERVICE	9,220
		0
		0
		0
		0
		42,558
7	OTHER	
	SCAVENGER	31,453
	SECURITY SERVICE	
		0
		0
		31,453
9	MEDICAL DIRECTOR	
	MEDICAL DIRECTOR FEES XVIII B 36-2	6,000
		6,000

LINE	SCHED REF	TOTAL
10	NURSING	
	CONTRACT NURSING XVIII C 53-2	
	LABORATORY & XRAY EXPENSE	305
	PURCHASED SERVICES	0
	PSYCHO-SOCIAL CONSULTANT XVIII B __-2	0
	RESTORATIVE NURSING CONSULTANT XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT XVIII B 37-2	0
	PHARMACY CONSULTANT XVIII B 39-2	1,440
	UTILIZATION REVIEW FEES XVIII B __-2	0
	PHYSICIANS XVIII B __-2	0
	PSYCHIATRIC XVIII B __-2	0
	RN CONSULTANT XVIII B 38-2	0
		0
		0
		1,745
10a	THERAPY	
	PHYSICAL THERAPY SERVICES	83
	SPEECH THERAPY SERVICES	825
	OCCUPATIONAL THERAPY SERVICES	66
	REHABILITATION CONSULTANT XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT XVIII B 43-2	0
	THERAPY CONTRACT SERVICES	15,747
		16,721
11	ACTIVITIES	
	CABLE TV - PATIENT ROOMS	
	ACTIVITY REHAB CONSULTANT XVIII B 44-2	2,496
		0
		2,496
12	SOCIAL SERVICES	
	SOCIAL REHABILITATION SERVICES	
	SOCIAL REHABILITATION CONSULTAN XVIII B 45-2	0
	SOCIAL WORKER XVIII B 45-2	0
		0
		0
		0
13	NURSE AIDE TRAINING	
	NURSE AIDE TRAINING COSTS XIII	0
		0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	76
		0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	125,000
	DIRECTORS FEES	
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	12,133
	ADMINISTRATIVE CONSULTANTS XIX C	77,500
	PROFESSIONAL FEES XIX C	22,110
		0
		111,743
20	FEES,SUBSCRIPTIONS,PROMOTIONS	
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	27,735
	EMPLOYEE WANT ADS XIX F	300
	CONTRIBUTIONS VI 20 XIX F	0
	DUES & SUBSCRIPTIONS XIX F	930
	LICENSES & PERMITS XIX F	1,904
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	9,705
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	0
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	120
	PATIENT BACKGROUND CHECKS XIX F	111
		40,805
21	CLERICAL & GENERAL OFFICE EXPENSES	
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	309
	EQUIPMENT REPAIR & MAINTENANCE	5,587
	OUTSIDE CLERICAL SERVICES	55,606
	PENALTIES / OVERDRAFT CHARGES VI 18	12,338
	HOME OFFICE EXPENSE	56,524
	THEFT & DAMAGE LOSS	0
	TELEPHONE	21,465
	MESSENGER SERVICE	787
		0
		152,616

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	204,138
	UNEMPLOYMENT COMPENSATION XIX D	64,415
	WORKERS COMPENSATION INSURANC XIX D	65,183
	HOSPITALIZATION INSURANCE XIX D	83,858
	EMPLOYEE BENEFITS - OTHER XIX D	1,518
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	24,514
	CHICAGO HEAD TAX XIX D	3,901
		0
		447,527
23	INSERVICE TRAINING & EDUCATION	
	EDUCATION & SEMINARS	0
		0
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	1,294
	TRAVEL XIX G	1,658
		2,952
25	ADMIN. STAFF TRANSPORTATION	
	TRANSPORTATION - STAFF	830
		830
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	309,952
		309,952
27	OTHER	
	BAD DEBTS VI 24	22,000
		22,000

GRAND TOTAL COLUMN 3 OTHER

1,478,683

AVENUE CARE NURSING & REHAB CENTER
SCHEDULES
12/31/2009

EMPLOYEE MEAL RECLASSIFICATION
PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22

TOTAL FOOD PURCHASE	217,331
LESS SALES TAX	<u>(311)</u>
NET FOOD	217,020

TOTAL PATIENT CENSUS	48,501
TIME 3 MEALS PER DAY	<u>3</u>
TOTAL PATIENT MEALS	145,503

ADD # EMPLOYEE MEALS/DAY	45
TIME # DAYS	<u>365</u>
TOTAL EMPLOYEE MEALS	16,425

PATIENT MEALS	145,503
ADD EMPLOYEE MEALS	<u>16,425</u>
TOTAL MEALS/YEAR	161,928

NET FOOD	217,020
DIVIDE TOTAL MEALS/YEAR	<u>161,928</u>

COST PER MEAL	1.34
TIME EMPLOYEE MEALS	<u>16,425</u>
EMPLOYEE MEAL RECLASSIFICATION	22,010

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V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			75,614	75,614		75,614	110,920	186,534			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			7,582	7,582		7,582	573,401	580,983			32
33	Real Estate Taxes			169,813	169,813		169,813	5,503	175,316			33
34	Rent-Facility & Grounds			500,825	500,825		500,825	(500,825)				34
35	Rent-Equipment & Vehicles			30,584	30,584		30,584	7,872	38,456			35
36	Other (specify):* OFFICE RENT			22,200	22,200		22,200	(22,200)				36
37	TOTAL Ownership			806,618	806,618		806,618	174,671	981,289			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		91,339	249,045	340,384		340,384		340,384			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,864	84,864		84,864		84,864			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		91,339	333,909	425,248		425,248		425,248			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,694,649	539,847	2,619,210	5,853,706		5,853,706	122,320	5,976,026			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	BHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,968)	30		9
10	Interest and Other Investment Income	(16,677)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(311)	2		13
14	Non-Care Related Interest	(267)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(12,338)	21		18
19	Entertainment		20		19
20	Contributions		20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(22,000)	27		24
25	Fund Raising, Advertising and Promotional	(27,735)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(9,705)	20		28
29	Other-Attach Schedule SEE PAGE 5A	1,359			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (93,642)		\$	30

BHF USE ONLY					
48		49		50	
				51	
					52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	215,962		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 215,962		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 122,320		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
 AVENUE CARE NURSING & REHAB CENTER

Report Period Beginning: 01/01/2009
 Ending: 12/31/2009

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 1359	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32

33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total		1,359	49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number AVENUE CARE NURSING & REHAB CENTER

0050732

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(311)	0	0	0	0	0	0	0	0	0	0	(311)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	1,359	14,815	0	4	0	0	0	0	0	0	0	16,178	6
7	Other (specify):*	0	101	0	0	0	0	0	0	0	0	0	101	7
8	TOTAL General Services	1,048	14,916	0	4	0	15,968	8						
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	26,437	0	0	0	0	0	0	0	0	0	26,437	10
10a	Therapy	0	6,650	0	0	0	0	0	0	0	0	0	6,650	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	33,087	0	0	0	0	0	0	0	0	0	33,087	16
	C. General Administration													
17	Administrative	0	(125,000)	114,550	0	0	0	0	0	0	0	0	(10,450)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(77,500)	8,784	0	0	0	0	0	0	0	0	(68,716)	19
20	Fees, Subscriptions & Promotions	(37,440)	0	1,927	25	0	0	0	0	0	0	0	(35,488)	20
21	Clerical & General Office Expenses	(12,338)	(46,500)	93,435	(64,584)	0	0	0	0	0	0	0	(29,987)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	895	228	0	0	0	0	0	0	0	1,123	23
24	Travel and Seminar	0	0	218	8	0	0	0	0	0	0	0	226	24
25	Other Admin. Staff Transportation	0	0	9,601	1,961	0	0	0	0	0	0	0	11,562	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,694	0	0	0	0	0	0	0	0	1,694	26
27	Other (specify):*	(22,000)	0	48,164	2,466	0	0	0	0	0	0	0	28,630	27
28	TOTAL General Administration	(71,778)	(249,000)	279,268	(59,896)	0	(101,406)	28						
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(70,730)	(200,997)	279,268	(59,892)	0	(52,351)	29						

STATE OF ILLINOIS

Summary B

Facility Name & ID Number AVENUE CARE NURSING & REHAB CENTER# 0050732

Report Period Beginning:

01/01/2009 Ending:

12/31/2009

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(5,968)	0	8,050	108,838	0	0	0	0	0	0	0	110,920	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(16,944)	0	93,959	496,386	0	0	0	0	0	0	0	573,401	32
33	Real Estate Taxes	0	0	5,503	0	0	0	0	0	0	0	0	5,503	33
34	Rent-Facility & Grounds	0	0	0	(500,825)	0	0	0	0	0	0	0	(500,825)	34
35	Rent-Equipment & Vehicles	0	0	7,872	0	0	0	0	0	0	0	0	7,872	35
36	Other (specify):*	0	(22,200)	0	0	0	0	0	0	0	0	0	(22,200)	36
37	TOTAL Ownership	(22,912)	(22,200)	115,384	104,399	0	174,671	37						
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(93,642)	(223,197)	394,652	44,507	0	0	0	0	0	0	0	122,320	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGT.	EVANSTON	MGMT/CLERICAL
				CAREPLUS REHAB	EVANSTON	THERAPY
SEE ATTACHED SCHEDULE		SEE ATTACHED SCHEDULE		EXTENDED CARE CONSULTING	EVANSTON	MGMT/CLERICAL
				AVENUE ASSOC.		
				LLC	EVANSTON	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
1	V	17	MANAGEMENT FEES	\$ 125,000	CAREPLUS MANAGEMENT, INC.		\$	(125,000)	1
2	V	19	ADMIN. CONSULT. FEES	77,500				(77,500)	2
3	V	21	CLERICAL FEES	46,500				(46,500)	3
4	V	36	OFFICE RENT	22,200				(22,200)	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V	6	MAINT AND REPAIR		CAREPLUS MANAGEMENT, INC.			7,895	9
10	V	6	MAINTENANCE SALARIES					6,920	10
11	V	7	SCAVENGER & SECURITY					101	11
12	V	10	NURSING SALARIES					26,437	12
13	V	10A	THERAPY SALARIES					6,650	13
14	Total			\$ 271,200			\$	48,003	\$ * (223,197) 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:		
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)		
15	V	17 ADMIN. SALARIES	\$	CAREPLUS MANAGEMENT, INC.		\$ 114,550	\$	114,550	15
16	V	19 PROFESSIONAL FEES				8,784		8,784	16
17	V	20 ADVERTISING				1,927		1,927	17
18	V	21 TOTAL OFFICE				18,822		18,822	18
19	V	21 CLERICAL SALARIES				74,613		74,613	19
20	V	23 SEMINARS				895		895	20
21	V	24 TRAVEL				218		218	21
22	V	25 TRANSPORTATION				9,601		9,601	22
23	V	26 INSURANCE				1,694		1,694	23
24	V	27 EMPLOYEE BENEFITS				48,164		48,164	24
25	V	30 DEPRECIATION (SL)				8,050		8,050	25
26	V	32 INTEREST				88,137		88,137	26
27	V	32 INTEREST-TAG 18 PPTY-MTG				5,822		5,822	27
28	V	33 REAL ESTATE TAX-TAG 18 PPTY				5,503		5,503	28
29	V	35 EQUIPMENT RENT				7,872		7,872	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total		\$			\$ 394,652	\$ *	394,652	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. YES NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	30 SL DEPRECIATION	\$	CAREPLUS REHABILITATIVE SERVICES		\$ 5,092	\$ 5,092
16	V						
17	V						
18	V						
19	V	21 CLERICAL FEES	9,106	EXTENDED CARE CONSULTING/CLINICAL			(9,106)
20	V	21 HOME OFFICE EXPENSES	56,524				(56,524)
21	V	6 MAINTENANCE & REPAIR				4	4
22	V	20 DUES/LICENSES				25	25
23	V	21 OFFICE EXPENSES				1,046	1,046
24	V	23 SEMINARS				228	228
25	V	24 TRAVEL				8	8
26	V	25 TRANSPORTATION				1,961	1,961
27	V	27 EMPLOYEE BENEFITS				2,466	2,466
28	V						
29	V						
30	V						
31	V						
32	V	34 RENT	500,825	AVENUE ASSOCIATES, LLC			(500,825)
33	V	30 SL DEPRECIATION				103,746	103,746
34	V	32 INTEREST				496,386	496,386
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 566,455			\$ 610,962	\$ * 44,507

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number AVENUE CARE NURSING & REHAB CE # 0050732 Report Period Beginning: 01/01/2009 Ending: 12/31/2009

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

1	2	3	4	5	6		7		8	9
					Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	CAREPLUS MGMT ALLOCATIONS							\$		1
2	SHERWIN I. RAY	PRESIDENT	ADMINISTRAT.	SEE	5.4	13.62	SALARY	26,566	17-7	2
3			FINANCE	ATTACHED						3
4				SCHEDULE						4
5	ROSLYN INDICH	CONTOLLER-A/P	CLERICAL		5.4	13.62	SALARY	8,111	17-7	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13							TOTAL	\$ 34,677		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number AVENUE CARE NURSING & REHAB CENTER # 0050732 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization CAREPLUS MANAGEMENT, INC.
 Street Address 2201 MAIN ST
 City / State / Zip Code EVANSTON, IL 60202-1519
 Phone Number (847) 905-3000
 Fax Number (847) 491-9565

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINT AND REPAIR	CENSUS DAYS	8	\$ 57,951	\$ 48,501	48,501	\$ 7,895	1
2	6	MAINTENANCE SALARIES	CENSUS DAYS	8	50,792	50,792	48,501	6,920	2
3	7	SCAVENGER & SECURITY	CENSUS DAYS	8	738		48,501	101	3
4	10	NURSING SALARIES	CENSUS DAYS	8	194,059	194,059	48,501	26,437	4
5	10A	THERAPY SALARIES	CENSUS DAYS	8	48,814	48,814	48,501	6,650	5
6	17	ADMIN. SALARIES	CENSUS DAYS	8	840,831	840,831	48,501	114,550	6
7	19	PROFESSIONAL FEES	CENSUS DAYS	8	64,478		48,501	8,784	7
8	20	ADVERTISING	CENSUS DAYS	8	14,148		48,501	1,927	8
9	21	TOTAL OFFICE	CENSUS DAYS	8	138,156		48,501	18,822	9
10	21	CLERICAL SALARIES	CENSUS DAYS	8	547,685	547,685	48,501	74,613	10
11	23	SEMINARS	CENSUS DAYS	8	6,573		48,501	895	11
12	24	TRAVEL	CENSUS DAYS	8	1,601		48,501	218	12
13	25	TRANSPORTATION	CENSUS DAYS	8	70,475		48,501	9,601	13
14	26	INSURANCE	CENSUS DAYS	8	12,432		48,501	1,694	14
15	27	EMPLOYEE BENEFITS	CENSUS DAYS	8	353,538		48,501	48,164	15
16	30	DEPRECIATION (SL)	CENSUS DAYS	8	59,093		48,501	8,050	16
17	32	INTEREST	CENSUS DAYS	8	646,953		48,501	88,137	17
18	32	INTEREST-TAG 18 PPTY-MTG	CENSUS DAYS	8	42,734		48,501	5,822	18
19	33	REAL ESTATE TAX-TAG 18 PPTY	CENSUS DAYS	8	40,394		48,501	5,503	19
20	35	EQUIPMENT RENT	CENSUS DAYS	8	57,785		48,501	7,872	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 3,249,230	\$ 1,682,181		\$ 442,655	25

Facility Name & ID Number AVENUE CARE NURSING & REHAB CENTER # 0050732 Report Period Beginning: 01/01/2009 Ending: 2/31/2009

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES NO

Name of Related Organization EXTENDED CARE CONSULTING/CLINICAL
 Street Address 2201 MAIN ST
 City / State / Zip Code EVANSTON, IL 60202-1519
 Phone Number (847) 905-3000
 Fax Number (847) 491-9565

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	6	MAINTENANCE & REPAIR	CENSUS DAYS	58,508	8	\$ 32	8,051	\$ 4	1
2	20	DUES/LICENSES	CENSUS DAYS	58,508	8	184	8,051	25	2
3	21	OFFICE EXPENSES	CENSUS DAYS	58,508	8	7,605	8,051	1,046	3
4	23	SEMINARS	CENSUS DAYS	58,508	8	1,657	8,051	228	4
5	24	TRAVEL	CENSUS DAYS	58,508	8	57	8,051	8	5
6	25	TRANSPORTATION	CENSUS DAYS	58,508	8	14,249	8,051	1,961	6
7	27	EMPLOYEE BENEFITS	CENSUS DAYS	58,508	8	17,921	8,051	2,466	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 41,705	\$	\$ 5,738	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1	Name of Lender	2		3	4	5	6		8	9	10						
		Related**					Purpose of Loan	Monthly Payment Required				Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
		YES	NO										Original	Balance			
A. Directly Facility Related																	
Long-Term																	
1	RELATED PARTY: AVENUE ASSOCIATES LLC						\$	\$			\$	1					
2	PACIFIC MUTUAL		X	MORTGAGE		12/95	4,657,452	3,456,951			496,386	2					
3												3					
4												4					
5												5					
Working Capital																	
6	A.I. IMPERIAL CREDIT		X	INSURANCE FINANCE							2,480	6					
7	CAREPLUS MGMT	X		WORKING CAPITAL							4,835	7					
8	CAREPLUS MGMT. ALLOCATION										93,959	8					
9	TOTAL Facility Related						\$ 4,657,452	\$ 3,456,951			\$ 597,660	9					
B. Non-Facility Related*																	
10	IRS, IDR, ETC		X	LATE FEES							267	10					
11												11					
12												12					
13												13					
14	TOTAL Non-Facility Related						\$	\$			\$ 267	14					
15	TOTALS (line 9+line14)						\$ 4,657,452	\$ 3,456,951			\$ 597,927	15					

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill

1. Real Estate Tax accrual used on 2008 report.	\$	174,616	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	174,622	2
3. Under or (over) accrual (line 2 minus line 1).	\$	6	3
4. Real Estate Tax accrual used for 2009 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	176,062	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ 6,255 For 2005 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$	(6,255)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	169,813	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	2004	176,255	8
	2005	178,049	9
	2006	174,753	10
	2007	172,887	11
	2008	174,622	12

FOR BHF USE ONLY			
13	FROM R. E. TAX STATEMENT FOR 2008	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

THE CURRENT YEAR REAL ESTATE ACCRUAL FOR AVENUE CARE CENTER INC IS BASED ON ~ 101% OF PRIOR YEAR REAL ESTATE TAX BILL FOR 10 MONTH = 145,504 PLUS FOR AVENUE CARE NURSING & REHAB CENTER, LLC =30,558 THE PAYMENT ON LINE 2 APPLIES TO THE 2008 TAX BILL

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ <u>174,621.80</u>	\$ <u>174,621.80</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2008 tax bills which were listed in Section A to this statement. Be sure to use the 2008 tax bill which is normally paid during 2009.

PLEASE NOTE: *Payment information from the Internet* or otherwise is *not considered acceptable tax bill documentation* . Facilities located in Cook County are required to provide copies of their original **second installment tax bill.**

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,293 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
 If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____
 3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	NURSING HOME	51,736	1995	\$ 100,000	1
2					2
3	TOTALS	51,736		\$ 100,000	3

Facility Name & ID Number AVENUE CARE NURSING & REHAB CENTER

0050732

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR BHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	155		1995	1971	\$ 4,046,250	\$ 103,746	39	\$ 103,746	\$	\$ 1,543,363	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9		SPRINKLER SYSTEM		1988	5,400	171	25	216	45	4,662	9
10		LEASEHOLD IMPROVEMENTS		1989	1,035	33	20	47	14	1,035	10
11		LEASEHOLD IMPROVEMENTS		1990	5,400	171	20	270	99	5,287	11
12		LEASEHOLD IMPROVEMENTS		1991	14,414	458	20	721	263	13,339	12
13		LEASEHOLD IMPROVEMENTS		1992	40,065	1,288	31.5	1,288		23,721	13
14		LEASEHOLD IMPROVEMENTS		1993	16,403	431	31.5	431		8,056	14
15		LEASEHOLD IMPROVEMENTS		1993	1,081		15			1,081	15
16		LEASEHOLD IMPROVEMENTS		1994	15,686	402	39	402		6,299	16
17		LEASEHOLD IMPROVEMENTS		1994	9,604		20	480	480	7,440	17
18		ELEVATOR REPAIR & DOOR		1995	44,614	1,144	39	1,144		16,350	18
19		PAVING		1995	3,600	240	15	240		3,480	19
20		ALARM SYSTEM		1996	1,820	47	39	47		644	20
21		PLUMBING		1996	2,737	70	39	70		954	21
22		WALK-IN COOLER		1996	9,998	256	39	256		3,399	22
23		DOORS AND ROOF REPAIR		1997	5,110	131	39	131		1,683	23
24		FENCE		1997	19,800	508	39	508		6,371	24
25		FLOORING/BUMPER GUARDRAILS/HANDRAILS		1997	30,579	784	39	784		9,717	25
26		BUILT-IN NURSES' STATION & WARDROBES		1997	26,176	671	39	671		8,389	26
27		SMOKE & FIRE DAMPERS		1998	7,100	182	39	182		2,039	27
28		ELEVATOR REPAIR AND LAUNDRY ROOM ELECTRICAL/CIRCU		1998	5,931	152	39	152		1,770	28
29		PARKING LOT PAVING AND LANDSCAPING		1998	53,109	3,133	15	3,541	408	40,859	29
30		FLOORING		1998	11,516	295	39	295		3,381	30
31		FIRE SAFETY UPGRADE/LIGHTING/EXHAUST/ROOF		1999	57,028	1,462	39	1,462		15,411	31
32		ONE SUMP PUMP ASSEMBLY		2000	4,200	153	27.5	153		1,396	32
33		RELOCATION OF A/C UNIT		2000	3,015	109	27.5	109		1,006	33
34		INSTALL PULL STATION & REWIRE BLDG		2000	5,878	214	27.5	214		1,953	34
35		CONCRETE STAIRS & RAMP REPLACEMENT		2001	20,000	727	27.5	727		6,210	35
36		REPLACEMENT CARPET-1ST FLOOR		2001	2,422		20	121		1,089	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number AVENUE CARE NURSING & REHAB CENTER

0050732

Report Period Beginning:

01/01/2009

Ending:

12/31/2009

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	LANDSCAPE INSTALLATION	2001	\$ 2,910	\$ 172	15	\$ 194	\$ 22	\$ 1,910	37
38	REPAIR PASSENGER & SMALL SERVICE ELEVATORS	2001	11,654	424	27.5	424		3,516	38
39	DECK	2001	12,170	719	15	811	92	7,989	39
40	SECOND FLOOR RESIDENT ROOMS-CLOSETS	2001	26,075	948	27.5	948		7,782	40
41	REPLACE PUMP MOTOR ON THE PASSENGER ELEVATOR	2002	2,580	94	27.5	94		748	41
42	BATHROOMS - INSTALLATION OF NEW SHEET VINYL	2002	1,297	47	27.5	47		331	42
43	RESIDENT BATHROOMS-NEW FLOOR	2003	3,274	119	27.5	119		818	43
44	INSTALLATION OF FIRE SPRINKLERS	2003	3,454	126	27.5	126		866	44
45	INSTALL NEW FRAMES FOR SLIDING DOORS	2003	2,765	101	27.5	101		660	45
46	BASEMENT CORRIDOR - FLOORING	2003	7,286	265	27.5	265		1,689	46
47	REPLACEMENT OF SEWER PIPES	2003	11,562	488	27.5	488		3,182	47
48	RECOVERY EXISTING CANOPY	2004	2,500	91	27.5	91		527	48
49	REMODELING BATHROOMS	2004	14,490	527	27.5	527		2,652	49
50	PAINTING HALLWAY	2005	15,280	1,727	20	1,727		4,783	50
51	INSTALL NEW SIGNS	2006	4,100	273	15	273		1,092	51
52	NEW LANDSCAPING	2006	26,080	1,739	15	1,739		6,956	52
53	REPLACED HOT WATER HEATER	2006	5,185	189	27.5	189		654	53
54	INSTALL SMOKE DETECTORS & FIRE ALARM SYSTEM	2006	10,239	372	27.5	372		1,287	54
55	INSTALL NEW ROOF DRAINS	2006	2,850	104	27.5	104		359	55
56	INSTALL EMERGENCY LIGHTS	2006	3,552	129	27.5	129		446	56
57	INSTALL NEW SHRUB ZONE	2006	2,125	77	27.5	77		266	57
58	3RD FLOOR SHOWERS ROOMS	2006	22,568	821	27.5	821		2,840	58
59	INSTALLED EXHAUST FAN FOR SMOKING ROOM	2007	3,012	110	27.5	110		280	59
60	REHAB OF BUILDING AND RESIDENT BATHROOMS:	2007	360,377	13,105	27.5	13,105		34,401	60
61	INSTALLATION OF NEW TOILETS, SINKS AND FAUCETS,								61
62	DOOR LOCKS, TILE WALL & FLOORS, PLUMBING, REPAINT,								62
63	REPLACE DRYWALLS, ELECTRIC WORK, EMERGENCY								63
64	CLEAN-UP OF ASBESTOS								64
65	CUSTOM WINDOW TREATMENTS & CUBICLE CURTAINS	2007	18,883	3,626	5	3,626		13,446	65
66	ELEVATOR MODERNIZATION	2007	12,800	465	27.5	465		1,259	66
67	INSTALL NEW STEM WELL	2007	2,656	97	27.5	97		246	67
68	BASEMENT DINNING A/C UNIT	2007	2,899	105	27.5	105		267	68
69	INSTALLED NEW ELEVATOR TRAVELING CABLES	2008	3,320	121	27.5	121		227	69
70	TOTAL (lines 4 thru 69)		\$ 5,067,914	\$ 144,159		\$ 145,703	\$ 1,423	\$ 1,841,863	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number AVENUE CARE NURSING & REHAB CENTER

0050732

Report Period Beginning:

01/01/2009 Ending: 12/31/2009

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,067,914	\$ 144,159		\$ 145,703	\$ 1,544	\$ 1,841,863	1
2	INSTALLED NEW CIRCUITS AND OUTLETS	2008	3,500	127	27.5	127		164	2
3	REHAB OF BUILDING AND RESIDENT BATHROOMS	2008	51,225	1,863	27.5	1,863		2,872	3
4	INSTALLATION OF NEW TOILETS, SINKS AND FAUCETS,								4
5	DOOR LOCKS,TILE WALLS & FLOORS,PLUMBING, REPAINT,								5
6	REPLACE DRYWALLS, ELECTRIC WORK								6
7	INSTALL NEW PIPING & DRAIN SYSTEM-1ST,2ND FLOOR	2008	22,975	835	27.5	835		1,287	7
8	PASSENGER ELEVATOR-CHANGED SEALS AND PACKING	2008	4,863	177	27.5	177		273	8
9	REPLACED CAR SILLS IN FREGHT ELEVATOR	2008	6,400	233	27.5	233		243	9
10	INSTALLED & PROGRAMMED ADA PHONES IN ELEVATOR	2009	10,271	295	27.5	295		295	10
11	FIRE ALARM PANEL REPLACEMENT	2009	26,447	681	27.5	681		681	11
12	REPLACED CABLE,ADJUST ELEVATOR DOOR OPERATOR	2009	3,534	81	27.5	81		81	12
13	WALL AIR CONDITIONERS	2009	3,659	2,194	5	2,194		2,194	13
14	INSTALLED FIRE DAMPERS	2009	3,367	56	27.5	56		56	14
15	INSTALLED NEW 5 TON A/C CONDENSING UNIT	2009	2,455	1,474	5	1,474		1,474	15
16	TUCKPOINTING	2009	5,850	9	27.5	9		9	16
17									17
18									18
19									19
20									20
21	RELATED PARTY ALLOCATION								21
22	CAREPLUS REHAB								22
23	NEW ROOF VENTILATOR	2003	909	23	39	23			23
24									24
25									25
26	CAREPLUS MGMT								26
27	BUILDING-TAG-18 PROPERTIES	2004	58,370	2,060	39	2,060			27
28	BUILDING IMPROVEMENTS-TAG-18 PROPERTIES	2004	22,931	1,241	39	1,241			28
29	BULDING IMPROVEMENTS-CAREPLUS MGMT	2007		9	39	9			29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 5,294,670	\$ 155,517		\$ 157,061	\$ 1,544	\$ 1,851,492	34

**Improvement type must be detailed in order for the cost report to be considered complete

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 192,281	\$ 10,626	\$ 18,043	\$ 7,417	8-15	\$ 109,610	71
72	Current Year Purchases	32,424	16,550	1,621	(14,929)	8-10	1,621	72
73	Fully Depreciated Assets	149,965					149,965	73
74	RELATED PARTY SL DEPRECIATION		9,809	9,809				74
75	TOTALS	\$ 374,670	\$ 36,985	\$ 29,473	\$ (7,512)		\$ 261,196	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 5,769,340	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 192,502	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 186,534	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (5,968)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,112,688	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____ \$ _____

13. _____ \$ _____

14. _____ \$ _____

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: YES NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO

16. Rental Amount for movable equipment: \$ 18,844 Description: SEE SCHEDULE ATTACHED

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>FACILITY</u>	<u>2006 FORD E35C</u>	\$ <u>626.25</u>	\$ <u>10,228</u>	17
18	<u>ADMINISTRATIVE</u>	<u>2006 BUICK</u>	<u>756.16</u>	<u>1,512</u>	18
19					19
20					20
21	TOTAL		\$ #####	\$ 11,740	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number AVENUE CARE NURSING & REHAB CENTER # 0050732 Report Period Beginning: 01/01/2009 Ending: 12/31/2009
XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

<p>1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES</p>	<p>2. <u>CLASSROOM PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>	<p>3. <u>CLINICAL PORTION:</u></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER CNA _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		Facility			Total
		1	2	3	
		Drop-outs	Completed	Contract	
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

\$

D. NUMBER OF CNAs TRAINED

COMPLETED		
1. From this facility		
2. From other facilities (f)		
DROP-OUTS		
1. From this facility		
2. From other facilities (f)		
TOTAL TRAINED		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	Service	1 Schedule V Line & Column Reference	2		3		4		5		6		7		8		
			Staff		Units of Service	Cost	Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units	Cost			Units	Cost									
1	Licensed Occupational Therapist	39-3	hrs	\$				\$	19,586	\$					\$	19,586	1
2	Licensed Speech and Language Development Therapist	39-3	hrs						1,518							1,518	2
3	Licensed Recreational Therapist		hrs														3
4	Licensed Physical Therapist	39-3	hrs						227,941							227,941	4
5	Physician Care		visits														5
6	Dental Care		visits														6
7	Work Related Program		hrs														7
8	Habilitation		hrs														8
9	Pharmacy	39-2	# of prescrpts							90,739						90,739	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs														10
11	Academic Education		hrs														11
12	Other (specify):																12
13	Other (specify): <u>MEDICAL SUPPLIES</u>	39-2								600						600	13
14	TOTAL			\$				\$	249,045	\$	91,339			\$	340,384		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number AVENUE CARE NURSING & REHAB CENTER

0050732

Report Period Beginning: 01/01/2009

Ending:

12/31/2009

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2009

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 26,216	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance 22,000)	1,022,838		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	37,601		6
7	Other Prepaid Expenses	21,509		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Real Estate Tax Escrow	23,056		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,131,220	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	5,850		15
16	Equipment, at Historical Cost	5,126		16
17	Accumulated Depreciation (book methods)	(180)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 10,796	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,142,016	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 347,850	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	624,591		29
30	Accrued Salaries Payable	38,293		30
31	Accrued Taxes Payable (excluding real estate taxes)	3,767		31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,558		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,045,059	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,045,059	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 96,957	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,142,016	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$	6
A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	647,000	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) <u>ADJ FOR AVENUE CARE CENTER INC</u>	(550,043)	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 96,957	17
B. Transfers (Itemize):			
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 96,957	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 6,467,749	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,467,749	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	4,280	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 4,280	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	12,000	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 12,000	23
D. Non-Operating Revenue			
24	Contributions		24
25	Interest and Other Investment Income***	16,677	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 16,677	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)		29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,500,706	30

		2	
Expenses		Amount	
A. Operating Expenses			
31	General Services	1,035,632	31
32	Health Care	2,148,407	32
33	General Administration	1,437,801	33
B. Capital Expense			
34	Ownership	806,618	34
C. Ancillary Expense			
35	Special Cost Centers	340,384	35
36	Provider Participation Fee	84,864	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,853,706	40
41	Income before Income Taxes (line 30 minus line 40)**	647,000	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 647,000	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number AVENUE CARE NURSING & REHAB CENTER

0050732

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

	1	2**	3	4		
	# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage		
1	Director of Nursing	1,828	2,341	\$ 89,407	\$ 38.19	1
2	Assistant Director of Nursing	1,329	1,703	65,028	38.18	2
3	Registered Nurses	2,722	2,886	78,601	27.24	3
4	Licensed Practical Nurses	28,733	30,368	709,453	23.36	4
5	CNAs & Orderlies	64,136	69,520	660,216	9.50	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,795	6,165	81,767	13.26	8
9	Activity Director	2,011	2,064	21,348	10.34	9
10	Activity Assistants	5,500	6,066	58,310	9.61	10
11	Social Service Workers	3,344	3,723	64,045	17.20	11
12	Dietician					12
13	Food Service Supervisor	2,056	2,135	37,030	17.34	13
14	Head Cook	5,735	6,301	60,203	9.55	14
15	Cook Helpers/Assistants	10,479	11,219	94,348	8.41	15
16	Dishwashers					16
17	Maintenance Workers	7,838	8,154	75,499	9.26	17
18	Housekeepers	15,545	16,552	145,485	8.79	18
19	Laundry	5,323	6,029	67,204	11.15	19
20	Administrator	1,989	2,091	95,340	45.60	20
21	Assistant Administrator	1,957	2,098	57,463	27.39	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,943	4,252	51,907	12.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,942	2,033	18,728	9.21	31
32	Other Health Care(specify)	8,000	8,455	163,267	19.31	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	180,205	194,155	\$ 2,694,649 *	\$ 13.88	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference		
35	Dietary Consultant	M	\$ 8,570	1-3	35
36	Medical Director	O	6,000	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	1,440	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,496	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 18,506		49

C. CONTRACT NURSES

	1	2	3		
	Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference		
50	Registered Nurses		\$		50
51	Licensed Practical Nurses		N/A		51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount	Description	Amount	
JOANN BREW	ADMINISTRATOR	0	\$ 95,340	Workers' Compensation Insurance	\$ 65,183	IDPH License Fee	\$ 995	
MILA JEFFREY	ASST ADMIN	0	57,463	Unemployment Compensation Insurance	64,415	Advertising: Employee Recruitment	300	
				FICA Taxes	204,138	Health Care Worker Background Check	120	
				Employee Health Insurance	83,858	(Indicate # of checks performed <u>6</u>)		
				Employee Meals	22,010	Patient Background Checks <u>5</u>	111	
				Illinois Municipal Retirement Fund (IMRF)*		TRUST/FRANCHISE/CONTRIB/ETC	0	
				EMPLOYEE BENEFITS - OTHER	1,518	MARKETING/ADV/PROMO	37,440	
				EMPLOYEE PHYSICAL EXAMS	0	LICENSES/DUES/SUBSCRIPTIONS	1,839	
				PENSION/PROFIT SHARING PLANS	24,514	MGMT CO ALLOC	1,952	
				CHICAGO HEAD TAX	3,901	TRUST/FRANCHISE/CONTRIB/ETC	0	
				INSURANCE - EXECUTIVE LIFE	0	Less: Public Relations Expense (0)	
				INSURANCE - EXECUTIVE LIFE VI 21	0	Non-allowable advertising	(27,735)	
						Yellow page advertising	(9,705)	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)				TOTAL (agree to Schedule V, line 22, col.8)			TOTAL (agree to Sch. V, line 20, col. 8)	
\$ 152,803				\$ 469,537			\$ 5,317	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
CAREPLUS MGMT	MANAGEMENT FEES		\$ 125,000				Out-of-State Travel	\$
							In-State Travel	
								1,658
							MGMT CO ALLOC	226
							Seminar Expense	
								1,294
							Entertainment Expense ()
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)				TOTAL			TOTAL (agree to Sch. V, line 24, col. 8)	
\$ 125,000				\$			\$ 3,178	
C. Professional Services								
Vendor/Payee	Type		Amount					
AMERICAN DATA	DATA PROCESSING		\$ 4,177					
NATIONAL DATACARE	DATA PROCESSING		1,915					
EMDEON BUSINESS SERVICE	DATA PROCESSING		350					
MDI ACHIVE	DATA PROCESSING		1,602					
ENBO SYSTEM	DATA PROCESSING		77					
E-HEALTH DATA SOLUTIONS	DATA PROCESSING		4,012					
CAREPLUS MGMT	ADMINISTRATIVE CONS		77,500					
KBKB, LTD	ACCOUNTING FEES		11,500					
MEYER MAGENCE	LEGAL FEES		2,915					
FINKEL,MARTWICK & COLSON	LEGAL FEES		1,564					
ECONOCARE	PURCHASE CONSULT.		1,395					
PERSONNEL PLANNER	UC CONSULTANT		4,736					
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$5,000, attach copy of invoices.)								
\$ 111,743								

* Attach copy of IMRF notifications

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13
Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	FY2006	FY2007	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014
1	PAINT/DECORATING	07/06	\$ 8,150	3 YRS	\$ 1,359	\$ 2,716	\$ 2,716	\$ 1,359	\$	\$	\$	\$
2												
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17												
18												
19												
20	TOTALS		\$ 8,150		\$ 1,359	\$ 2,716	\$ 2,716	\$ 1,359	\$	\$	\$	\$

Facility Name & ID Number AVENUE CARE NURSING & REHAB CENTER

0050732

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? YES
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 113 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES X NO _____ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
AVENUE CARE CENTER INC # 0033340 11/1/09
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 84,864
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 22,010 Has any meal income been offset against related costs? N/A Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 5%
d. Have vehicle usage logs been maintained? NO
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$5,000, have legal invoices and a summary of services performed been attached to this cost report? N/A
Attach invoices and a summary of services for all architect and appraisal fees.